Student Asthma Action Card

Name: ______________________ D.O.B. ____________ Grade: ______ Age: ______

Teacher: ______________________________ Room: ____________

Parent/Guardian Name: ______________________ Ph: (H) ____________
Address: ______________________ Ph: (W) ____________
____

Emergency Phone Contact: ____________ ____________ ____________
Name Relationship Phone

Physician Student Sees for Asthma: ______________________ Ph: ____________

Other Physician: ______________________ Ph: ____________

Peak Flow Monitoring: Personal Best Peak Flow ____________

Asthma Severity Level:
- ☐ Mild Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Allergies: ______________________________

Daily Medication Plan:

	Name	Amount	When to Use
1.			
2.			
3.			

Special Instructions or Comments:

____
____
____

For Inhaled Medications:

- ☐ 0.5cc Albuterol & normal saline via nebulizer or 2 puffs Albuterol inhaler.
- ☐ 1 amp 0.63mg Xopenex unit dose via nebulizer or 2 puffs Xopenex inhaler.
- ☐ ______________________________ (other medication)
- ☐ Is allowed to carry inhaler medication and use that medication by him/herself.

______________________________ ____________
Physician's Signature Date

______________________________ ____________
Parent's Signature Date

Food Allergy Action Plan

Student's Name:_______________ **D.O.B:**__________ **Teacher:**_______________

ALLERGY TO:_______________________________________

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
▪ If a food allergen has been ingested, but *no symptoms*:		☐ Epinephrine	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ Other†	______________________	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for instructions)

Antihistamine: give_______________________________________
medication/dose/route

Other: give_______________________________________
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: ______________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ______________________ at ______________________

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. ______________________	1.)______________	2.) ______________
b. ______________________	1.)______________	2.) ______________
c. ______________________	1.)______________	2.) ______________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature______________________________ Date__________

Doctor's Signature______________________________ Date__________
(Required)